Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
PO BOX 24809
HOUSTON TX 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TRAVELERS INDEMNITY CO OF CONNECTICUT

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-0624-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Denial on EOB states: Pre-Authorization not obtained. According to Rule §134.202(4): A maximum of three FCE's for each compensable injury shall be billed and reimbursed…We have performed and billed the FCE correctly, therefore request that you reconsider these bills in accordance with the medical fee guidelines."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider performed the FCE at the request of Dr. Syed on 12-17-2009. …The Carrier reviewed and denied reimbursement on the basis that Dr. was not the Claimant's Treating Doctor, and the Treating Doctor had not approved the procedure." "Dr. was not the Claimant's Treating Doctor at the time the services were delivered, and the proper Treating Doctor, Dr. , did not request or approve the FCE. Rule 180.22(c) states the Treating Doctor shall approve or recommend all non-emergency healthcare. As documented by the DWC-53, attached, the Division did not approve the requested change of Treating Doctor until 12-29-2009. Therefore, Dr. was not authorized to request the FCE without the approval of DR. . As no such approval was granted by Dr. , the FCE was unauthorized. The Provider is consequently not entitled to reimbursement.

Response Submitted by: Travelers; 1501 South Mopac Expwy; Ste A-320; Austin TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2009	97750-FC (16 units)	$800.00	$521.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
4. Texas Labor Code §413.031(c) states, "In resolving disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment given the relevant statutory provisions and commissioner rules…"
5. Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 18, 2010
   - 38 – Services not provided or authorized by designated (network/primary care) providers.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Was the health care provider eligible to perform the services billed?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305 (a)(4) states, "Medical Fee Dispute—A dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is resolved by the Division of Workers' Compensation (Division) pursuant to Division rules, including §133.307 of this subchapter (relating to MDR of Fee Disputes)." 28 Texas Administrative Code §133.307 (a) (3) states that the role of the Division is to adjudicate the payment, given the relevant statutory provisions and Division rules.

2. Per the DWC-53, the health care provider was approved to perform the services billed.

3. 28 Texas Administrative Code §134.204 (g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c) (1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. A review of the FCE report supports billed hours from 12:00pm to 3:00pm for a total of 12 units. Recommend reimbursement as follows:
   - 53.68 ÷ 36.0666 x $94.36 x 12 units = $521.52

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $521.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $521.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		MAY , 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.